

		FOR OHF USE					

LL 1

**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0005108</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																									
<b>Facility Name:</b> <u>Oakridge Convalescent Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
<b>Address:</b> <u>323 Oakridge</u> <u>Hillside</u> <u>60162</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
<b>County:</b> <u>Cook</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
<b>Telephone Number:</b> <u>(708) 547-6595</u> <b>Fax #</b> <u>(708) 547-6598</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) <u>Randall S. Sylvan</u> (Firm Name & Address) <u>Africk/Chez, P.C.</u> <u>770 Lake Cook Road, Suite 350, Deerfield, IL 60015</u> (Telephone) <u>(847) 236-9800</u> Fax # <u>(847) 236-9805</u>																									
<b>IDPA ID Number:</b> <u>36-2664179-001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
<b>Date of Initial License for Current Owners:</b> <u>1973</u>																											
<b>Type of Ownership:</b> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
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	<input checked="" type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Randall S. Sylvan</u> <b>Telephone Number:</b> <u>(847) 236-9800</u>																											

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakridge Convalescent Home# 0005108 Report Period Beginning: 01/01/02 Ending: 12/31/02

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>58</u>	Skilled (SNF)	<u>58</u>	<u>21,170</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>15</u>	Intermediate (ICF)	<u>15</u>	<u>5,475</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>73</u>	TOTALS	<u>73</u>	<u>26,645</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,724</u>	<u>579</u>	<u>785</u>	<u>3,088</u>	8
9	SNF/PED					9
10	ICF	<u>14,834</u>	<u>7,678</u>	<u>183</u>	<u>22,695</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,558</u>	<u>8,257</u>	<u>968</u>	<u>25,783</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 96.76%

D. How many bed-hold days during this year were paid by Public Aid?

191 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?  
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒I. On what date did you start providing long term care at this location?  
Date started / /1962

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number  
of beds certified 5 and days of care provided 785Medicare Intermediary AdminaStar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Oakridge Convalescent Home # 0005108 Report Period Beginning: 01/01/02 Ending: 12/31/02

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	139,080	11,954		151,034		151,034		151,034		1
2	Food Purchase		156,097		156,097		156,097		156,097		2
3	Housekeeping	24,617	33,064		57,681		57,681		57,681		3
4	Laundry	67,418			67,418		67,418		67,418		4
5	Heat and Other Utilities			88,795	88,795		88,795		88,795		5
6	Maintenance	135,334	33,004	24,537	192,875		192,875		192,875		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	366,449	234,119	113,332	713,900		713,900		713,900		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,250	8,250		8,250		8,250		9
10	Nursing and Medical Records	986,513	79,115	3,722	1,069,350		1,069,350		1,069,350		10
10a	Therapy										10a
11	Activities	76,047		42,184	118,231		118,231		118,231		11
12	Social Services										12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,062,560	79,115	54,156	1,195,831		1,195,831		1,195,831		16
	<b>C. General Administration</b>										
17	Administrative	83,200			83,200	7,355	90,555		90,555		17
18	Directors Fees										18
19	Professional Services			14,832	14,832		14,832		14,832		19
20	Dues, Fees, Subscriptions & Promotions			47,042	47,042		47,042	(34,285)	12,757		20
21	Clerical & General Office Expenses	70,558	26,885	9,648	107,091		107,091		107,091		21
22	Employee Benefits & Payroll Taxes			230,408	230,408	26,911	257,319	(7,744)	249,575		22
23	Inservice Training & Education										23
24	Travel and Seminar			19,621	19,621		19,621	(12,165)	7,456		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			132,999	132,999	(34,266)	98,733	(3,330)	95,403		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	153,758	26,885	454,550	635,193		635,193	(57,524)	577,669		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,582,767	340,119	622,038	2,544,924		2,544,924	(57,524)	2,487,400		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Oakridge Convalescent Home

#0005108

Report Period Beginning:

01/01/02

Ending:

12/31/02

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			50,615	50,615		50,615	(8,396)	42,219			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,406	15,406		15,406		15,406			32
33	Real Estate Taxes							83,067	83,067			33
34	Rent-Facility & Grounds			208,200	208,200		208,200	(208,200)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			274,221	274,221		274,221	(133,529)	140,692			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		29,237	17,015	46,252		46,252		46,252			39
40	Barber and Beauty Shops			8,989	8,989		8,989		8,989			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,967	39,967		39,967		39,967			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		29,237	65,971	95,208		95,208		95,208			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,582,767	369,356	962,230	2,914,353		2,914,353	(191,053)	2,723,300			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**      A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	7,101	V ln 30		9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions	(15,497)	V ln 30		15
16 Personal Expenses (Including Transportation)	(12,165)	V ln 24		16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(34,285)	V ln 20		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(11,074)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (65,920)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(125,133)	V ln 33-4	34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (125,133)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (191,053)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
 (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Oakridge Convalescent Home

ID# 0005108

Report Period Beginning: 01/01/02

Ending: 12/31/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Non-care related Owners' Insurance	\$ (3,330)	V ln 26	1
2	Non-care related Owners' Insurance	(7,744)	V ln 22	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(11,074)		49

## Summary A

12/31/02

12/31/02

[illegible]

## Summary B

12/31/02

[illegible]



Facility Name & ID Number Oakridge Convalescent Home# 0005108

Report Period Beginning:

01/01/02

Ending:

12/31/02

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael & Lynn Acerra	100	N/A		323 Oakridge Blvd	Hillside, IL	Individual

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	33	Real Estate Taxes	\$		100.00%	\$ 83,067	\$ 83,067	1
2	V	34	Rent	208,200	Michael & Lynn Acerra	100.00%		(208,200)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 208,200			\$ 83,067	\$ * (125,133)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakridge Convalescent Home # 0005108 Report Period Beginning: 01/01/02 Ending: 12/31/02

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Acerra	President	Operations	100.00		10	100.00	Salary	\$ 36,400	In 6, col 1	1
2	Lynn Acerra	Secretary	Administrator			40	100.00	Salary	83,200	In 17, col 1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 119,600		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakridge Convalescent Home# 0005108 Report Period Beginning: 01/01/02 Ending: 12/31/02

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

Fax Number (\_\_\_\_) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakridge Convalescent Home # 0005108 Report Period Beginning: 01/01/02 Ending: 12/31/02

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Harris Bank		X	Medical Equipment	\$900.31	1/10/00	\$ 37,972	\$ 18,941	12/10/04	15.4270	\$ 3,479	1	
2	Lexus Financial Services		X	Transporation Equipment	\$1,008.23	4/2/99	48,977	15,212	4/17/04	8.5000	1,775	2	
3	Lexus Financial Services		X	Transporation Equipment	\$1,058.30	9/10/98	43,770		9/10/02	7.5000	291	3	
4												4	
5												5	
	Working Capital												
6	Harris Bank		X	Operating Expense			257,025	169,975		3.3300	8,144	6	
7	Harris Bank		X	Operating Expense			35,000	35,257		9.5000	1,717	7	
8												8	
9	TOTAL Facility Related				\$2,966.84		\$ 422,744	\$ 239,385			\$ 15,406	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 422,744	\$ 239,385			\$ 15,406	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Oakridge Convalescent Home**# **0005108** Report Period Beginning: **01/01/02** Ending: **12/31/02****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> <b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																																				
1. Real Estate Tax accrual used on 2001 report.		\$ <b>81,907</b>	1																																	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ <b>80,475</b>	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>(1,432)</b>	3																																	
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>84,499</b>	4																																	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5																																	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$      For      Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>83,067</b>	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1997</td><td><b>72,707</b></td><td>8</td></tr> <tr><td>1998</td><td><b>73,655</b></td><td>9</td></tr> <tr><td>1999</td><td><b>73,436</b></td><td>10</td></tr> <tr><td>2000</td><td><b>78,007</b></td><td>11</td></tr> <tr><td>2001</td><td><b>80,475</b></td><td>12</td></tr> </table>	1997	<b>72,707</b>	8	1998	<b>73,655</b>	9	1999	<b>73,436</b>	10	2000	<b>78,007</b>	11	2001	<b>80,475</b>	12	<table border="1"> <tr><td colspan="2"><b>FOR OHF USE ONLY</b></td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2001</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	<b>FOR OHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2001	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
1997	<b>72,707</b>	8																																		
1998	<b>73,655</b>	9																																		
1999	<b>73,436</b>	10																																		
2000	<b>78,007</b>	11																																		
2001	<b>80,475</b>	12																																		
<b>FOR OHF USE ONLY</b>																																				
13	FROM R. E. TAX STATEMENT FOR 2001	\$	13																																	
14	PLUS APPEAL COST FROM LINE 5	\$	14																																	
15	LESS REFUND FROM LINE 6	\$	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																	
<b>80475 x 1.05 = 84449</b>																																				

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Oakridge Convalescent Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0005108

CONTACT PERSON REGARDING THIS REPORT Randall S. Sylvan

TELEPHONE (847) 236-9800 FAX #: (847) 236-9805

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>15-17-413-067-0000</u>	<u>323 Oakridge, Hillside, IL 60162</u>	\$ <u>39,925.15</u>	\$ <u>39,925.15</u>
2. <u>15-17-413-052-0000</u>	<u>323 Oakridge, Hillside, IL 60162</u>	\$ <u>40,549.74</u>	\$ <u>40,549.74</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>80,474.89</u>	\$ <u>80,474.89</u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? \_\_\_\_\_ YES \_\_\_\_\_ X \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet:

15,008

B. General Construction Type:

Exterior

Brick

Frame

Fire Alarm Spr

Number of Stories

1

C. Does the Operating Entity?

☐
 (a) Own the Facility

☒
 (b) Rent from a Related Organization.

☐
 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒
 (a) Own the Equipment

☐
 (b) Rent equipment from a Related Organization.

☐
 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐
 YES

☒
 NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		39,186	1962	\$ 30,000	1
2					2
3	TOTALS	39,186		\$ 30,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	61	1962	1962	\$ 221,884	\$	30	\$	\$	\$ 221,884
5	12	1973	1973	81,204		25			81,204
6									
7									
8									
Improvement Type**									
9	Building	1982		2,647		15			2,647
10	Roof	1983		2,700		15			2,700
11	Building	1984		3,503	70	15	184	114	3,503
12	Building	1985		29,621	1,244	25	1,185	(59)	21,330
13	Building	1986		15,084	634	25	604	(30)	10,251
14	Roof Repairs & Latch Door	1988		9,000	286	25	360	74	5,400
15	Roof Repairs	1990		22,971	729	25	919	190	11,947
16	Carpeting	1991		1,291		5			1,291
17	Building Additions	1992		68,671	2,180	25	2,747	567	27,470
18	Roof	1993		7,968	797	25		(797)	7,968
19	HVAC	1993		12,594	1,259	25	504	(755)	9,743
20	Building Additions	1993		41,579	1,320	25	1,663	343	17,856
21	Roof	1994		7,000	700	25	280	(420)	2,240
22	Nursing Station Addition	1995		3,624	362	25	145	(217)	1,160
23	Lobby Remodeling	1996		3,311		25	132	132	924
24	HVAC	1996		8,796	880	25	352	(528)	2,464
25	Boiler	2001		11,500	1,150	25	460	(690)	3,220
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

**See Page 12A, Line 70 for total**

SEE ACCOUNTANTS' COMPILATION REPORT



**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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54									54
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 554,948	\$ 11,611		\$ 9,535	\$ (2,076)	\$ 435,202	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 481,153	\$ 22,759	\$ 31,885	\$ 9,126		\$ 262,505	71
72	Current Year Purchases	11,982	748	799	51			72
73	Fully Depreciated Assets	257,000					257,000	73
74								74
75	TOTALS	\$ 750,135	\$ 23,507	\$ 32,684	\$ 9,177		\$ 519,505	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,335,083	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 35,118	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 42,219	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,101	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 954,707	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Lexus 1999	\$ 49,977	\$ 9,995	\$ 34,984	86
87	Lexus 1998	55,023	5,502	27,512	87
88	Lexus	57,705		33,076	88
89	Building Improvements- Fully Depr.	138,872		138,872	89
90					90
91	TOTALS	\$ 301,577	\$ 15,497	\$ 234,444	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT



A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <input type="text"/></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <input type="text"/></p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed			Contract	Total
1	Community College Tuition	\$	\$			\$	\$
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$			\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$					

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist	39-3	64 hrs	\$ 4,090		\$		\$	64	\$ 4,090	1				
2	Licensed Speech and Language Development Therapist	39-3	45 hrs	3,739					45	3,739	2				
3	Licensed Recreational Therapist		hrs								3				
4	Licensed Physical Therapist	39-3	198 hrs	9,186					198	9,186	4				
5	Physician Care		visits								5				
6	Dental Care		visits								6				
7	Work Related Program		hrs								7				
8	Habilitation		hrs								8				
9	Pharmacy	39-2	# of prescripts					29,237		29,237	9				
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10				
11	Academic Education		hrs								11				
12	Exceptional Care Program										12				
13	Other (specify):										13				
14	TOTAL			\$ 17,015		\$	\$ 29,237		307	\$ 46,252	14				

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Oakridge Convalescent Home

# 0005108

Report Period Beginning: 01/01/02

Ending:

12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	433,496	433,496	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	102,615	102,615	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 536,111	\$ 536,111	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		30,000	13
14	Buildings, at Historical Cost		303,088	14
15	Leasehold Improvements, at Historical Cost	390,733	390,733	15
16	Equipment, at Historical Cost	912,840	912,840	16
17	Accumulated Depreciation (book methods)	(1,057,260)	(1,360,348)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 246,313	\$ 276,313	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 782,424	\$ 812,424	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 64,321	\$ 64,321	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	225,661	225,661	29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	10,074	10,074	31
32	Accrued Real Estate Taxes(Sch.IX-B)		84,449	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Checks in Excess of Funds on Dep.	21,627	21,627	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 321,683	\$ 406,132	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	13,928	13,928	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 13,928	\$ 13,928	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 335,611	\$ 420,060	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 446,813	\$ 392,364	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 782,424	\$ 812,424	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 252,994</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 252,994</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>193,819</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 193,819</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 446,813</b>	<b>24</b>

\*

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 19

Facility Name &amp; ID Number Oakridge Convalescent Home

# 0005108

Report Period Beginning: 01/01/02

Ending:

12/31/02

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,108,172	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,108,172	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,108,172	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	713,900	31
32	Health Care	1,195,831	32
33	General Administration	635,193	33
	<b>B. Capital Expense</b>		
34	Ownership	274,221	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	55,241	35
36	Provider Participation Fee	39,967	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,914,353	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	193,819	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 193,819	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



Facility Name & ID Number **Oakridge Convalescent Home**# **0005108**Report Period Beginning: **01/01/02**Ending: **12/31/02**

12/31/02

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 77,372	\$ 37.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,561	11,839	370,980	31.34	3
4	Licensed Practical Nurses	207	207	4,245	20.51	4
5	Nurse Aides & Orderlies	51,792	53,914	533,916	9.90	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,080	28,558	13.73	9
10	Activity Assistants	4,567	4,717	47,489	10.07	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	29,447	14.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,766	8,782	109,633	12.48	15
16	Dishwashers					16
17	Maintenance Workers	9,782	10,324	135,334	13.11	17
18	Housekeepers	2,129	2,321	24,617	10.61	18
19	Laundry	7,090	7,466	67,418	9.03	19
20	Administrator	2,000	2,080	83,200	40.00	20
21	Assistant Administrator					21
22	Other Administrative	3,920	4,160	70,558	16.96	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	106,814	112,050	\$ 1,582,767 *	\$ 14.13	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	415	8,250	Ln 9 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	415	\$ 8,250		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	242	3,722	Ln 10 Col 3	52
53	TOTAL (lines 50 - 52)	242	\$ 3,722		53

SEE ACCOUNTANTS' COMPILATION REPORT

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Lynn Acerra		Administrator	0	\$ 83,200	Workers' Compensation Insurance		\$ 34,266	IDPH License Fee		\$	
					Unemployment Compensation Insurance		11,849	Advertising: Employee Recruitment		8,455	
					FICA Taxes		128,071	Health Care Worker Background Check (Indicate # of checks performed _____)			
					Employee Health Insurance		86,845	Dues & Association Fees		4,267	
					Employee Meals			Promotional		34,285	
					Illinois Municipal Retirement Fund (IMRF)*			Subscriptions		35	
					401(k) Match		3,643				
					Less: Admn Payroll Taxes		(7,355)				
					Less: Owners' Insurance		(7,744)				
								</			

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakridge Convalescent Home

STATE OF ILLINOIS

# 0005108

Report Period Beginning:

01/01/02

Ending:

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12/31/02

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,983 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. \_\_\_\_\_
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over \_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 39,967  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. \_\_\_\_\_

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 90%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.